		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029132

Facility Name: COMMUNITY CARE CENTER

Address: 4314 WABASH AVE. (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (773) 538-8300 **Fax #** (773) 538-5775

IDPA ID Number: 36-3327511

Date of Initial License for Current Owners: 11/26/84

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3	59	Intermediate (ICF)	59	21,535	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			5,774	5,774	8
9	SNF/PED					9
10	ICF	66,050	52	177	66,279	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,050	52	5,951	72,053	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.77%

D. How many bed-hold days during this year were paid by Public Aid?
428 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/26/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/26/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 5,774

Medicare Intermediary ADMINISTAR OF ILLINOIS

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	224,650	25,357	10,800	260,807		260,807		260,807			1
2	Food Purchase		284,788		284,788		284,788	(1,356)	283,432			2
3	Housekeeping	119,018	33,144		152,162		152,162		152,162			3
4	Laundry	107,907	24,010	2,806	134,723		134,723		134,723			4
5	Heat and Other Utilities			141,542	141,542		141,542	583	142,125			5
6	Maintenance	105,532	33,975	65,771	205,278		205,278	3,437	208,715			6
7	Other (specify):*			20,572	20,572		20,572	42	20,614			7
8	**TOTAL General Services**	557,107	401,274	241,491	1,199,872		1,199,872	2,706	1,202,578			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,727,608	87,893	19,561	1,835,062		1,835,062		1,835,062			10
10a	Therapy	20,501			20,501		20,501		20,501			10a
11	Activities	403	7,969	2,040	10,412		10,412		10,412			11
12	Social Services	164,668		3,419	168,087		168,087		168,087			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,913,180	95,862	31,020	2,040,062		2,040,062		2,040,062			16
	C. General Administration											
17	Administrative	81,706		600,000	681,706		681,706	(577,268)	104,438			17
18	Directors Fees											18
19	Professional Services			78,602	78,602		78,602	9,631	88,233			19
20	Dues, Fees, Subscriptions & Promotions			22,222	22,222		22,222	(4,678)	17,544			20
21	Clerical & General Office Expenses	140,246	18,809	96,792	255,847		255,847	(69,761)	186,086			21
22	Employee Benefits & Payroll Taxes			339,315	339,315		339,315		339,315			22
23	Inservice Training & Education							40	40			23
24	Travel and Seminar			1,600	1,600		1,600		1,600			24
25	Other Admin. Staff Transportation			5,821	5,821		5,821	755	6,576			25
26	Insurance-Prop.Liab.Malpractice			127,387	127,387		127,387	1,007	128,394			26
27	Other (specify):*			222,912	222,912		222,912	(216,283)	6,629			27
28	**TOTAL General Administration**	221,952	18,809	1,494,651	1,735,412		1,735,412	(856,557)	878,855			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,692,239	515,945	1,767,162	4,975,346		4,975,346	(853,851)	4,121,495			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: COMMUNITY CARE CENTER **#0029132** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	0	
	REPAIRS & MAINTENANCE		10,800	
			0	10,800
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,806	
			0	2,806
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		59,049	
	ELECTRICITY		55,855	
	WATER		24,555	
	CABLE TV - LOBBY		2,083	
			0	141,542
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,790	
	PAINTING & DECORATING		1,043	
	BUILDING REPAIRS		12,045	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		19,846	
	ELEVATOR MAINTENANCE & REPAIR		13,472	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,794	
	FIRE SERVICE		6,781	
			0	
			0	
			0	65,771
7	**OTHER**			
	SCAVENGER		11,572	
	SECURITY SERVICE		9,000	20,572
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	500	
	LABORATORY & XRAY EXPENSE		2,645	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	1,301	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,420	
	PHARMACY CONSULTANT	XVIII B 39-2	8,670	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,025	
			0	19,561
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,040	
			0	2,040
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,419	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,419
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	600,000	600,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	23,294	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	55,308	
			0	78,602
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	250	
	EMPLOYEE WANT ADS	XIX F	238	
	CONTRIBUTIONS	VI 20 XIX F	1,000	
	DUES & SUBSCRIPTIONS	XIX F	7,910	
	LICENSES & PERMITS	XIX F	7,474	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	204	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,856	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,290	22,222
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		811	
	EQUIPMENT REPAIR & MAINTENANCE		5,064	
	OUTSIDE CLERICAL SERVICES		41,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	251	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,012	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		33,654	96,792

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	206,054	
	UNEMPLOYMENT COMPENSATION	XIX D	34,994	
	WORKERS COMPENSATION INSURANCI	XIX D	66,675	
	HOSPITALIZATION INSURANCE	XIX D	23,742	
	EMPLOYEE BENEFITS - OTHER	XIX D	254	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	7,596	339,315
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	1,600	
	TRAVEL	XIX G	0	
			0	
			0	1,600
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,821	5,821
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		127,387	127,387
27	**OTHER**			
	BAD DEBTS	VI 24	222,912	
			0	222,912

GRAND TOTAL COLUMN 3 OTHER 1,767,162

Facility Name & ID Number COMMUNITY CARE CENTER #0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			56,953	56,953		56,953	108,978	165,931			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,348	12,348		12,348	373,071	385,419			32
33	Real Estate Taxes							167,466	167,466			33
34	Rent-Facility & Grounds			777,192	777,192		777,192	(777,192)				34
35	Rent-Equipment & Vehicles			18,923	18,923		18,923	4,520	23,443			35
36	Other (specify):* **software amort**			3,100	3,100		3,100		3,100			36
37	**TOTAL Ownership**			868,516	868,516		868,516	(123,157)	745,359			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		108,039	379,004	487,043		487,043		487,043			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,690	111,690		111,690		111,690			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		108,039	490,694	598,733		598,733		598,733			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,692,239	623,984	3,126,372	6,442,595		6,442,595	(977,008)	5,465,587			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,602	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,356)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(251)	21		18
19	Entertainment		20		19
20	Contributions	(4,856)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(222,912)	27		24
25	Fund Raising, Advertising and Promotional	(250)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(204)	20		28
29	Other-Attach Schedule	(362,507)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (585,734)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(391,274)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (391,274)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (977,008)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

COMMUNITY CARE CENTER

ID# 0029132

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(28,042)	21	2
3	BANK CHARGES	(811)	21	3
4	STAFF DEVELOPMENT	(33,654)	21	4
5	YOSEF DAVIS MANAGEMENT FEES	(300,000)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(362,507)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,356)	0	0	0	0	0	0	0	0	0	0	(1,356)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	583	0	0	0	0	0	0	0	583	5
6	Maintenance	0	0	2,506	931	0	0	0	0	0	0	0	3,437	6
7	Other (specify):*	0	0	42	0	0	0	0	0	0	0	0	42	7
8	**TOTAL General Services**	(1,356)	0	2,548	1,514	0	0	0	0	0	0	0	2,706	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(300,000)	(284,934)	7,666	0	0	0	0	0	0	0	0	(577,268)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	194	9,189	248	0	0	0	0	0	0	0	9,631	19
20	Fees, Subscriptions & Promotions	(5,310)	0	632	0	0	0	0	0	0	0	0	(4,678)	20
21	Clerical & General Office Expenses	(62,758)	8,033	(15,154)	118	0	0	0	0	0	0	0	(69,761)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	40	0	0	0	0	0	0	0	0	40	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	232	523	0	0	0	0	0	0	0	0	755	25
26	Insurance-Prop.Liab.Malpractice	0	180	710	117	0	0	0	0	0	0	0	1,007	26
27	Other (specify):*	(222,912)	2,561	4,068	0	0	0	0	0	0	0	0	(216,283)	27
28	**TOTAL General Administration**	(590,980)	(273,734)	7,674	483	0	0	0	0	0	0	0	(856,557)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(592,336)	(273,734)	10,222	1,997	0	0	0	0	0	0	0	(853,851)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,602	1,118	278	1,568	99,412	0	0	0	0	0	0	108,978	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	2,417	370,654	0	0	0	0	0	0	373,071	32
33	Real Estate Taxes	0	0	0	3,006	164,460	0	0	0	0	0	0	167,466	33
34	Rent-Facility & Grounds	0	0	0	(15,912)	(761,280)	0	0	0	0	0	0	(777,192)	34
35	Rent-Equipment & Vehicles	0	0	4,373	147	0	0	0	0	0	0	0	4,520	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,602	1,118	4,651	(8,774)	(126,754)	0	0	0	0	0	0	(123,157)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(585,734)	(272,616)	14,873	(6,777)	(126,754)	0	0	0	0	0	0	(977,008)	45

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
YOSEF DAVIS	50	SEE ATTACHED SCHEDULE		EKS MGMT.	LINCOLNWOOD	BOOKKEEPING
MORRIS ESFORMES	50			EMI ENTERPRISES	LINCOLNWOOD	MGMT. CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE
				RSM	LINCOLNWOOD	LANDLORD

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 300,000	EMI ENTERPRISES		$	$ (300,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				15,066	15,066	4
5	V	19	ACCOUNTING FEES				194	194	5
6	V	21	OFFICE EXPENSE				8,033	8,033	6
7	V	25	TRANSPORTATION				232	232	7
8	V	26	INSURANCE				180	180	8
9	V	27	EMPLOYEE BENEFITS				2,561	2,561	9
10	V	30	DEPRECIATION				1,118	1,118	10
11	V	35	AUTO LEASE						11
12	V								12
13	V								13
14	Total			$ 300,000			$ 27,384	$ * (272,616)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 41,000	EKS MANAGEMENT, INC.		$	$ (41,000)	15
16	V								16
17	V								17
18	V	6	PAINTERS SALARIES				2,506	2,506	18
19	V	7	SCAVENGER				42	42	19
20	V	17	CFO SALARY				7,666	7,666	20
21	V	19	PROFESSIONAL FEES				9,189	9,189	21
22	V	20	WANT ADS				632	632	22
23	V	21	OFFICE EXPENSE				25,846	25,846	23
24	V	23	SEMINARS				40	40	24
25	V								25
26	V	25	TRANSPORTATION				523	523	26
27	V	26	INSURANCE				710	710	27
28	V	27	EMPLOYEE BENEFITS				4,068	4,068	28
29	V	30	DEPRECIATION				278	278	29
30	V	35	EQUIPMENT RENTAL				4,373	4,373	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,000			$ 55,873	$ * 14,873	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	OFFICE RENT	$ 15,912	IME REALTY CORP.		$	$ (15,912)	15
16	V								16
17	V								17
18	V	5	UTILITIES				583	583	18
19	V	6	REPAIRS				931	931	19
20	V	19	PROFESSIONAL FEES				248	248	20
21	V	21	OFFICE EXPENSE				118	118	21
22	V	26	INSURANCE				117	117	22
23	V	30	DEPRECIATION				1,568	1,568	23
24	V	32	INTEREST				2,417	2,417	24
25	V	33	RE TAX				3,006	3,006	25
26	V	35	STORAGE FEES				147	147	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,912			$ 9,135	$ * (6,777)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 761,280	RSM NURSING ASSOCIATES	100.00%	$	$ (761,280)	15
16	V	30	DEPRECIATION				99,412	99,412	16
17	V	32	INTEREST				370,654	370,654	17
18	V	33	REAL ESTATE TAXES				164,460	164,460	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 761,280			$ 634,526	$ * (126,754)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	MORRIS ESFORMES	OFFICER	ADMINISTRATIVE		SEE ATTACHED			SALARY	15,066	17-8	2
3											3
4											4
5	AVRUM WEINFELD	CFO	FINAN. OFFICER		SEE ATTACHED			SALARY	7,666	17-8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,732		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PATIENT DAYS	884,739	14	$ 185,000	$ 185,000	72,053	$ 15,066	1
2	19	ACCOUNTING FEES	PATIENT DAYS	884,739	14	2,381		72,053	194	2
3	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	98,637	76,255	72,053	8,033	3
4	25	TRANSPORTATION	PATIENT DAYS	884,739	14	2,845		72,053	232	4
5	26	INSURANCE	PATIENT DAYS	884,739	14	2,209		72,053	180	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	31,442		72,053	2,561	6
7										7
8	35	AUTO LEASE	PATIENT DAYS	884,739	14	13,730		72,053	1,118	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 336,244	$ 261,255		$ 27,384	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARY	PATIENT DAYS	884,739	14	$ 30,769	$ 30,769	72,053	$ 2,506	1
2	7	SCAVENGER	PATIENT DAYS	884,739	14	510		72,053	42	2
3	17	CFO SALARY	PATIENT DAYS	884,739	14	94,128	94,128	72,053	7,666	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	884,739	14	112,835		72,053	9,189	4
5	20	WANT ADS	PATIENT DAYS	884,739	14	7,759		72,053	632	5
6	21	OFFICE EXPENSE	PATIENT DAYS	884,739	14	317,364	228,335	72,053	25,846	6
7	23	SEMINARS	PATIENT DAYS	884,739	14	490		72,053	40	7
8										8
9	25	TRANSPORTATION	PATIENT DAYS	884,739	14	6,427		72,053	523	9
10	26	INSURANCE	PATIENT DAYS	884,739	14	8,715		72,053	710	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	884,739	14	49,951		72,053	4,068	11
12	30	DEPRECIATION	PATIENT DAYS	884,739	14	3,418		72,053	278	12
13	35	EQUIPMENT RENT	PATIENT DAYS	884,739	14	53,700		72,053	4,373	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 686,066	$ 353,232		$ 55,873	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	303,433	15	$ 11,111	$	15,912	$ 583	1
2	6	REPAIRS / MAINT	INCOME	303,433	15	17,749		15,912	931	2
3	19	PROFESSIONAL FEES	INCOME	303,433	15	4,725		15,912	248	3
4	21	OFFICE EXPENSE	INCOME	303,433	15	2,247		15,912	118	4
5	26	INSURANCE	INCOME	303,433	15	2,237		15,912	117	5
6	30	DEPRECIATION	INCOME	303,433	15	29,895		15,912	1,568	6
7	32	INTEREST	INCOME	303,433	15	46,095		15,912	2,417	7
8	33	RE TAX	INCOME	303,433	15	57,331		15,912	3,006	8
9	35	STORAGE FEES	INCOME	303,433	15	2,800		15,912	147	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,190	$		$ 9,135	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: RSM NURSING ASSOCIATES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 99,412	$	1	$ 99,412	1
2	32	INTEREST	DIRECT	1	1	370,654		1	370,654	2
3	33	REAL ESTATE TAXES	DIRECT	1	1	164,460		1	164,460	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,526	$		$ 634,526	25

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY ALLOC.						$	$			$ 2,417	1
2	RSM(DAVIS)	X			$5,000.00	9/1/94	465,000	161,989	11/01/06	0.0800	14,936	2
3	EMES LIMITED PARTNERSHIP		X		$975.00	9/1/94	127,440	31,886	12/01/06	0.0800	2,935	3
4												4
5	LASALLE(RSM)		X	MORTGAGE	$35,284.00	11/30/01	4,838,255	4,700,944	11/30/08	0.0735	352,783	5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME+	12,348	6
7												7
8												8
9	TOTAL Facility Related				$41,259.00		$ 5,430,695	$ 4,894,819			$ 385,419	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,430,695	$ 4,894,819			$ 385,419	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 160,986	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 162,792	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,806	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 162,791	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 137 For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (137)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 164,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	171,353	8
	1999	170,203	9
	2000	158,584	10
	2001	160,987	11
	2002	162,792	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME COMMUNITY CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0029132

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-03-300-021-0000	NURSING HOME	$ 3,706.76	$ 3,706.76
2.	20-03-300-022-0000	NURSING HOME	$ 38,729.36	$ 38,729.36
3.	20-03-300-023-0000	NURSING HOME	$ 39,526.48	$ 39,526.48
4.	20-03-300-024-0000	NURSING HOME	$ 38,948.32	$ 38,948.32
5.	20-03-300-025-0000	NURSING HOME	$ 38,152.80	$ 38,152.80
6.	20-03-300-026-0000	NURSING HOME	$ 3,727.79	$ 3,727.79
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 162,791.51	$ 162,791.51

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,088 B. General Construction Type: Exterior FRAME Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 98,640	1
2					2
3	TOTALS			$ 98,640	3

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	204				$ 2,393,321	$ 61,367	39	$ 61,367	$	$ 572,224	4
5											5
6											6
7											7
8	IME ALLOCATION					1,534		1,534			8
	Improvement Type**										
9	VARIOUS			1985	57,320					57,320	9
10	VARIOUS			1986	12,387		15	826	826	11,781	10
11	VARIOUS			1987	4,819	153	31.5	153		3,365	11
12	VARIOUS			1988	948	30	31.5	30		603	12
13	VARIOUS			1989	3,644	116	31.5	116		2,112	13
14	VARIOUS			1992	6,146	195	31.5	195		2,679	14
15	VARIOUS			1993	17,589	558	31.5	558		6,497	15
16	UNDERGROUND PLUMBING			1994	1,607	41	39	41		401	16
17	DOORS			1994	630	16	39	16		147	17
18	NURSING STATION			1995	3,000	77	39	77		690	18
19	INSTALLED BATH TUB			1995	8,606	221	39	221		1,920	19
20	ROOF REPAIR			1995	14,900	382	39	382		3,295	20
21	FLOOR COVERING			1995	9,876	253	39	253		2,233	21
22	ROOF WORK			1996	2,200	56	39	56		423	22
23	INSTALL NEW PUMP UNIT, CAR DOOR FOR ELEVATOR			1997	18,215	467	39	467		3,032	23
24	FURNISH & INSTALL BASE, VINYL - 3RD FLOOR			1997	38,100	977	39	977		6,310	24
25	INSTALL NEW MODIFIED ROOF SYSTEM			1997	5,150	132	39	132		1,676	25
26	CHAIN LINK FENCE			1998	3,723	248	15	248		1,271	26
27	FRONT ENTRY DOOR			1998	1,793	46	39	46		259	27
28	GREASE TRAP & TILES			1998	4,300	110	39	110		591	28
29	FIREDAMPERS WITH SLEEVES			1998	4,279	110	39	110		573	29
30	SEAL UP CRACKS AROUND THE BUILDING			1998	3,900	100	39	100		521	30
31	PLUMBING			1999	7,200	185	39	185		825	31
32	CEMENT AND ASPHALT WORK			1999	5,900	151	39	151		661	32
33	WALL PAPER			2000	5,155	644	7	736	92	3,997	33
34	BOILER			2000	4,537	165	27.5	165		502	34
35	AUDIT RCI GENERATOR			1986	8,181					8,181	35
36	AUDIT SUMP PUMP			1986	414					414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AUDIT EXHAUST FAN	1986	$ 1,132	$		$	$	$ 1,132	37
38	AUDIT CABINETS	1987	9,462					9,462	38
39	NURSING STATION	2001	24,600	894	27.5	894		2,272	39
40	DOORS	2001	6,867	250	27.5	250		635	40
41	TILING	2001	12,958	2,488	5	2,592	104	9,331	41
42	CARPETING	2001	6,344	1,218	5	1,269	51	4,568	42
43	TILING	2002	5,400	196	27.5	196		302	43
44	CARPETING	2002	1,438	322	5	288	(34)	576	44
45	FLOORING	2003	16,348	322	27.5	322		322	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,732,389	$ 74,024		$ 75,063	$ 1,039	$ 723,103	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 519,809	$ 45,063	$ 51,306	$ 6,243		$ 306,894	71
72	Current Year Purchases	1,743	767	87	(680)		87	72
73	Fully Depreciated Assets	189,242					189,242	73
74	EKS,IME,EMI,RSM ALLOC.	380,454	38,357	38,357			361,428	74
75	TOTALS	$ 1,091,248	$ 84,187	$ 89,750	$ 5,563		$ 857,651	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	BUS	1985	$ 600	$	$	$	3 YR	$ 600	76
77	FACILITY BUSINESS	79 GMC JIMMY	1988	2,994				5 YR	2,994	77
78	FACILITY BUSINESS	CHEVY	1990	24,000				5 YR	24,000	78
79										79
80	TOTALS			$ 27,594	$	$	$		$ 27,594	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,949,871	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 158,211	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 164,813	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,602	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,608,348	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,178 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	01 CHEVY VAN	$ 699.00	$ 2,106	17
18	FACILITY VAN	03 ECOLINE WAGON	699.00	3,639	18
19					19
20					20
21	TOTAL		$ #######	$ 5,745	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 184,220	$		$ 184,220	1
2	Licensed Speech and Language Development Therapist		hrs			784			784	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			194,000			194,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				82,705		82,705	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): lab,rentals, feeding						25,334		25,334	13
14	TOTAL			$		$ 379,004	$ 108,039		$ 487,043	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 813,952	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,229,618		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	103,496		6
7	Other Prepaid Expenses	19,882		7
8	Accounts Receivable (owners or related parties)	310,737		8
9	Other(specify): TAX DEPOSIT	24,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,501,685	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	299,139		15
16	Equipment, at Historical Cost	772,069		16
17	Accumulated Depreciation (book methods)	(793,920)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 277,288	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,778,973	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,662,170	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	143,320		30
31	Accrued Taxes Payable (excluding real estate taxes)	33,383		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,838,873	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,838,873	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,940,100	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,778,973	$	48

*(See instructions.)

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,113,676	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,113,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,694,427	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(868,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 826,427	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,940,100	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,833,947	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,833,947	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	300,859	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 300,859	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	816	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 816	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSION	1,400	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,400	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,137,022	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,199,872	31
32	Health Care	2,040,062	32
33	General Administration	1,735,412	33
	B. Capital Expense		
34	Ownership	868,516	34
	C. Ancillary Expense		
35	Special Cost Centers	487,043	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,442,595	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,694,427	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,694,427	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,119	4,250	$ 95,050	$ 22.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,177	6,370	123,493	19.39	3
4	Licensed Practical Nurses	37,010	38,188	689,232	18.05	4
5	Nurse Aides & Orderlies	89,050	93,013	695,748	7.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,734	1,969	20,501	10.41	8
9	Activity Director					9
10	Activity Assistants	78	78	403	5.17	10
11	Social Service Workers	18,836	20,080	164,668	8.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,990	30,454	224,650	7.38	15
16	Dishwashers					16
17	Maintenance Workers	9,177	9,437	105,532	11.18	17
18	Housekeepers	19,738	20,913	119,018	5.69	18
19	Laundry	13,698	14,393	107,907	7.50	19
20	Administrator	2,080	3,721	81,706	21.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,441	14,692	140,246	9.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,019	6,145	73,077	11.89	31
32	Other Health Care(specify)					32
33	Other(specify) Q.A., PA Specialist	3,366	3,453	51,008	14.77	33
34	TOTAL (lines 1 - 33)	254,513	267,156	$ 2,692,239 *	$ 10.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0	1-3	35
36	Medical Director	M	6,000	9-3	36
37	Medical Records Consultant	O	3,420	10-3	37
38	Nurse Consultant	N	0	10-3	38
39	Pharmacist Consultant	T	8,670	10-3	39
40	Physical Therapy Consultant	H	0	10a-3	40
41	Occupational Therapy Consultant	L	0	10a-3	41
42	Respiratory Therapy Consultant	Y	0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,040	11-3	44
45	Social Service Consultant	E	3,419	12-3	45
46	Other(specify)	E			46
47	DENTAL	S	3,025	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 26,574		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	40	500	10-3	52
53	TOTAL (lines 50 - 52)	40	$ 500		53

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DENISE MARTIN	ADMIN		$ 81,706
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,706

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 300,000
YOSEF DAVIS	300,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 600,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		78,602
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 78,602

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 66,675
Unemployment Compensation Insurance		34,994
FICA Taxes		206,054
Employee Health Insurance		23,742
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		254
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		7,596
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,080
Advertising: Employee Recruitment	238
Health Care Worker Background Check	1,290
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	454
TRUST/FRANCHISE/CONTRIB/ETC	4,856
LICENSES & PERMITS	1,394
DUES & SUBSCRIPTIONS	7,910
MGMT CO ALLOCATION	632
TRUST/FRANCHISE/CONTRIB/ETC	(4,856)
Less: Public Relations Expense	(0)
Non-allowable advertising	(250)
Yellow page advertising	(204)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,544

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	1,600
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,600

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number COMMUNITY CARE CENTER # 0029132 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $7,772**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,251** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees